Patient Name_____ ID _____ ADULT INTAKE SLEEP FORM

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Sleep Visit

Date:_____

Right or Left Handed Age:_____ Married/Single/Divorced/Significant Other/Other

Please answer the questions below as they apply to you.
Note: If you are using a CPAP machine, some of the questions may not apply to you.

Are you using a CPAP machine? ☐ Yes ☐ No
Do you drink alcohol in the evenings or before bed? ☐ Yes ☐ No
Normal Bedtime:_____
Number of time(s) you wake during the night on average:_____
What time do you get up in the morning?_____
Do you snore: ☐ Yes ☐ No
Has someone ever seen you pause in your breathing at night? ☐ Yes ☐ No
Are you sleepy during the day? ☐ Yes ☐ No
Do you take naps without meaning to? ☐ Yes ☐ No
Do you have pain in your legs before bed? ☐ Yes ☐ No

Do you wake with (circle all that apply):	Dry Throat	Sore Throat	Neither
While asleep, do you (circle all that apply):	Sleep Walk	Sleep Talk	Neither

EPWORTH SLEEPINESS SCALE (ESS)

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0 = would *never* doze
1 = *slight* chance of dozing
2 = *moderate* chance of dozing
3 = *high* chance of dozing

SITUATION	**CHANCE OF DOZING**
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g., a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
Total	**_____**